STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	02/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00103217. Complaint IN00103217 - Unsubstantiated due to lack of evidence Survey Dates: February 21, 22, 23, 24, 2012 Facility Number: 000059 Provider Number: 155697 AIM Number: 100266560 Survey Team: Dottie Navetta, RN TC Donna Groan, RN Avona Connell, RN Gloria Reisert, MSW Census bed type: SNF: 9 SNF/NF: 66 Total: 75 Census payor type: Medicare: 11 Medicaid: 58 Other: 6 Total: 75	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation on or after **March 25, 2012.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Sample: 15 Supplemental Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 2/29/12 by Suzanne Williams, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, record review and interview, the facility failed to notify the physician of medication not provided as ordered for 1 of 2 residents reviewed for physician notification in a supplemental	F0157	**What corrective**	03/25/2012

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	sample of 3. (Resident #70) Findings: On 2/23/12 at 10:45 a.m., Resident #70's physician was seated at the Nurse's Desk and was visibly upset an order for medication had not been started. The nurse standing at the desk indicated it would be taken care of right away. The clinical record for Resident #70 was reviewed on 2/23/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, dementia, diabetes type II and urinary tract infection. On 2/22/12 at 11 a.m., the physician ordered Macrobid (to treat a urinary tract infection) 500 mg (milligrams) BID (two times a day) for 7 days. On 2/23/12 at 11:37 a.m., in interview with LPN (Licensed Practical Nurse) #2, he indicated he worked second shift and was unable to get the order clarified. He passed the concern onto the next shift nurse. He heard the ordered medication had not been started. Staff failed to notify the physician after the pharmacy questioned the ordered medication for a clarification of the order. On 2/23/12 at 3:40 p.m., in interview with the Corporate Registered Nurse, she		**action(s) will be accomplished for those residents found to have been affected by the** Deficient practice: · Resident #70's antibiotic was started. **How will you identify other residents** Having the potential to be affected by the same deficient practice and what corrective action will be taken: · All residents have the potential to be affected by the alleged deficient practice. · The licensed nurses will be re-educated 3/13/12 by the DNS/designee on timely notification of physician. Post test included. · All physician orders are reviewed daily by the DNS/designee with follow-up using the daily minutes tool to ensure physician orders are in place and being followed.	

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	indicated pharmacy questioned the dose as there were no 500 mg tablets, only 50 and 100. On 2/24/12 at 1 p.m., review of the policy and procedure for Resident Change of Condition, dated revised 3/10, included, but was not limited to: "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs...3. Routine Medical Change a. All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly. Routine changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening. b. The nurse in charge is responsible for notification of physician and family/responsible party prior to end of assigned shift when a significant change in the resident's condition is noted. c. If unable to reach the physician or family/responsible party, all calls to physicians or exchanges and family/responsible party requesting callbacks will be documented in the medical record. d. If the physician has not returned the call by the end of the shift, the oncoming nurse will be notified for followup. e. If unable to contact		What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: · The licensed nurses will be re-educated 3/13/12 by the DNS/designee on timely notification of physician. · The director of nursing services/designee is responsible to ensure compliance. · All physician orders are reviewed daily by the DNS/designee with follow-up using the daily minutes tool to ensure physician orders are in place and being followed. · Non-compliance with these procedures and training will result in disciplinary action. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: · The change of condition and physician notification daily tool will be utilized daily x 4 weeks, bi-weekly x 2 months, monthly x 3 and for 3 quarters thereafter. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practices above the 95% threshold.	

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	attending physician or alternate timely, the Medical Director will be notified for response and intervention for the resident change of condition. f. Document resident change of condition and response in the medical record. Documentation will include time and family/physician response. g. The licensed nurse responsible for the resident will continue assessment and documentation in the medical record every shift until the residents condition has stabilized...." 3.1-5(a)(3)			

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F0203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State			

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	long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. Based on record review and interview, the facility failed to provide a Transfer/Discharge form which included reason for, date of, and/or transfer location, for 1 of 2 closed records reviewed in a sample of 15. (Resident #99) Finding includes: The clinical record for Resident #99 was reviewed on 2/22/12 at 4:25 p.m. The resident was discharged to another facility on 1/5/12. The record lacked a copy of the Transfer/Discharge form. On 2/24/12 at 8:10 a.m., in interview with the Medical Records Director, she called the other facility and they had no record of the form being sent on transfer. 3.1-12(a)(9)(A)	F0203	It is the practice of this provider to ensure all residents are made aware of any potential transfer/discharge in accordance with the thirty day required notification. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #99 has been discharged from this facility beyond the timeframe to appeal the discharge.. On 3/9/12 a copy of our discharge notice was mailed to ensure resident #99 had a copy for their records. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · An IDT review on 3/9/12	03/25/2012

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	3.1-12(a)(9)(B) 3.1-12(a)(9)(C) 3.1-12(a)(9)(E) 3.1-12(a)(9)(G)		revealed no residents that currently have the potential to be affected . · Any resident discharged will have appropriate discharge forms completed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Effective 3/9/12 all future discharge/transfers will be reviewed by the IDT before such action, when possible, or during the next IDT meeting to verify proper written notification has occurred. · Any resident identified during IDT review without proper notification will receive the appropriate forms the day of the IDT meeting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** **Medical Records Coordinator will report monthly for six months via the CQI meeting the number of discharges for the month and verification each received appropriate and complete forms/notification**	

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F0204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Based on record review and interview, the facility failed to provide sufficient preparation to a resident prior to being discharged. This deficient practice affected 1 of 2 discharged residents reviewed for discharge planning in a sample of 15 residents. (Resident #98) Finding includes: Review of the clinical record for Resident #98 on 2/22/2012 at 4:30 p.m., indicated the resident had diagnoses which included, but were not limited to: status post fractured tibia with fibula, muscle weakness, diabetes mellitus type I and hypotension. On 9/1/2011, a Notice of Transfer or Discharge was issued to the resident effective 10/1/2011, due to "The resident has failed, after reasonable and appropriate notice, to pay or payment has not been made under Medicare/Medicaid for a stay in a nursing facility." The notice indicated the resident was going to be discharged to her daughter's home.	F0204	It is the practice of this provider to ensure all residents are made aware of any potential transfer/discharge with sufficient preparation and orientation to ensure safe and orderly transfer/discharge from the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** · Resident #98 is no longer a resident of this facility. Resident was discharged per request to a facility the resident chose. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** · An IDT review on 3/9/12 indicated no resident in the facility at this time has the potential to be affected. · Residents discharged will have adequate discharge planning. **What measures will be put into place or what systemic**	03/25/2012

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	A 9/1/2011 Interdisciplinary Progress Note [IDT] indicated the team spoke with the family via phone about Medicaid and the issuing of the 30 day notice for non-payment. Documentation also noted the resident refused to attend this meeting. The next note regarding discharge was an Interdisciplinary Progress Note dated 9/28/2011, in which the family was courtesy called to remind them that APS [Adult Protective Services] would be notified for follow-up. The note also indicated the resident was informed she was to be discharged to her daughter's house. Documentation was lacking of any type of discussion with the resident or family between 9/1 and 10/1/2011 to determine what services, equipment or needs might be needed once the resident was discharged. During an interview with the Business Office Manager on 2/23/2012 at 10:10 a.m., she indicated that after researching the files, she could only guess the notice was issued because the resident did not make her Medicaid application in a timely manner causing her to be responsible for the bill the first 3 months she was admitted to the facility.		**changes you will make to ensure that the deficient practice does not recur?** · Effective 3/9/12 all future discharge/transfers will be reviewed by the IDT before such action, when possible, or during the next IDT meeting to verify proper written notification has occurred with appropriate discharge plans developed 14 days prior to discharge and such discharge/transfer has all applicable safety/orientation items addressed and documented. · Any resident identified during IDT review without proper notification of safety/orientation issues will receive the appropriate information the day of the IDT meeting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** · Social Services Director will report monthly for six months via the CQI meeting the number of discharges for the month and verification each received appropriate notification/communication regarding safety/orientation issues and discharge planning.	

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	On 2/23/2012 at 2:10 p.m., the Medical Records Director presented a copy of the facility's current policy on "Social Services Discharge procedures." Review of this policy at this time included, but was not limited to: "...4. The discharge plan will be formulated and reviewed with the resident/responsible party fourteen days prior to discharge from the facility. The outcome of the conference will be documented in the IDT note...7. While completion of the discharge plan of care involves all appropriate disciplines, Social Services will ensure that it has been completed prior to the resident's discharge...Social Services are the discharge planner, and it is your responsibility to make sure all education and services are in place and documented prior to a resident being discharged." 3.1-12(a)(21)			

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F0250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident received assistance in discharge planning in preparation to return home. This deficient practice affected 1 of 2 discharged residents reviewed for discharge planning in a sample of 15 residents. (Resident #98) Finding includes: Review of the clinical record for Resident #98 on 2/22/2012 at 4:30 p.m., indicated the resident had diagnoses which included, but were not limited to: status post fractured tibia with fibula, muscle weakness, diabetes mellitus type I and hypotension. On 9/1/2011, a Notice of Transfer or Discharge was issued to the resident effective 10/1/2011, due to "The resident has failed, after reasonable and appropriate notice, to pay or payment has not been made under Medicare/Medicaid for a stay in a nursing facility." The notice indicated the resident was going to be discharged to her daughter's home.	F0250	It is the practice of this provider to ensure that each resident receives assistance in discharge planning . **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** · Resident #98 is no longer a resident of this facility. Resident was discharged per request to a facility the resident chose. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** · An IDT review on 3/9/12 indicated no resident in the facility at this time has the potential to be affected. · Any resident discharged will have appropriate discharge forms completed. **What measures will be put into place or what systemic changes you will make to ensure that the alleged**	03/25/2012

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	A 9/1/2011 Interdisciplinary Progress Note indicated the team spoke with the family via phone about Medicaid and the issuing of the 30 day notice for non-payment. Documentation also noted the resident refused to attend this meeting. The next note regarding discharge was an Interdisciplinary Progress Note dated 9/28/2011, in which the family was courtesy called to remind them that APS [Adult Protective Services] would be notified for follow-up. The note also indicated the resident was informed she was to be discharged to her daughter's house. Documentation was lacking in the Social Services' notes of any type of discussion with the resident or family between 9/1 and 10/1/2011 to determine what services, equipment or needs might be required once the resident was discharged. A 5/13/2011 Care Plan by Social Services included, but was not limited to, the following: - "Problem: Discharge/psychosocial well being: resident and family may need to coordinate community resources for discharge plan: assisted living facility." - "Goal: Resident/family will provide information on special needs/services or equipment needs as discharge plan is		**deficient practice does not recur?** · Effective 3/9/12 all future discharge/transfers will be reviewed by the IDT before such action, when possible, or during the next IDT meeting to ensure social services are involved in the transfer/discharge process. · Any resident identified during IDT review without appropriate social services involvement will receive such services day of the IDT meeting through discharge/transfer.. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place.** · Social Services Director will report monthly for six months via the CQI meeting the number of discharges/transfers for the month and verification each received appropriate social services involvement, including discharge planning.	

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	coordinated." - "Approach: complete discharge forms and review with resident/family. -Encourage resident/family to express their expectations for discharge. - Provide information regarding community resources..." On 2/23/2012 at 2:10 p.m., the Medical Records Director presented a copy of the facility's current policy on "Social Services Discharge procedures." Review of this policy at this time included, but was not limited to: "Discharge planning starts the day of admission..3. Social Services will document updates on referrals, care plan meetings, and any changes made on the discharge plan in the social service progress note...4a. Social Services will document in the social services progress note any care plan meeting refuses or declines setting up services. 5. Social Services is responsible for coordinating with resident/responsible party and the appropriate disciplines/services to assist in education and preparation for discharge...7. While completion of the discharge plan of care involves all appropriate disciplines, Social Services will ensure that it has been completed prior to the resident's discharge...Social Services are the discharge planner, and it is your responsibility to make sure all education			

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	155697	A. BUILDING 00 B. WING	02/24/2012

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	and services are in place and documented prior to a resident being discharged." On 2/24/2012 at 11:00 a.m., the acting Director of Nursing [DoN] presented a copy of the "Job Description" for the facility Social Worker. Review of this "Job Description" included, but was not limited to: "...Essential Position Functions...Advises appropriate referrals to minimize social and economic obstacles to discharge. Coordinates discharge planning. Coordinates relocation planning, including advice and referral to community resources before or during relocation..." 3.1-34(a)			

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F0253 SS=C	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure furniture and equipment were clean in 1 of 2 dining rooms, 1 of 1 therapy room, and 1 of 1 laundry room, and 3 of 43 resident rooms. This deficient practice had the potential to affect 75 of 75 current residents. Findings include: On 02/21/12, the following was observed: 1. At 9:01 a.m., the wood frames of 13 of 13 chairs in the main dining room were soiled with heavy dust that rolled up when swiped with the fingers. The vents on both sides of the ice machine were soiled with heavy dust. In interview with the dietary manager at this time, she indicated maintenance was responsible for cleaning the ice machine. 2. At 12:09 p.m., the wood frames of 3 of 4 chairs in the therapy room were soiled with heavy dust. In interview with a therapist at this same time, she indicated housekeeping cleans the chairs and therapy cleans therapy equipment.	F0253	It is the practice of this provider to ensure housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** · All chairs in the dinning room were affectively cleaned on 2/25/2012. · All chairs in the therapy department were affectively cleaned on 2/25/2012. · Box fan in laundry was cleaned by housekeeping on 2/25/12 · On 3/9/12 all bed frames in the facility were appropriately cleaned. · The wall in room 24 was repaired accordingly on 3/12/12. · All mattress covers were cleaned by housekeeping on or before 2/25/12. · Ceiling vents in the main dining room were cleaned by housekeeping on 2/25/12. · Ice machine vents in the main dining room was cleaned by maintenance on 2/25/12. **How will you identify other residents having the potential**	03/25/2012

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	3. At 12:13 p.m., a box fan on the clean side of the laundry was soiled with heavy dust on the grill and blades. The laundry employee in interview at this time, when asked how often the fan was cleaned, replied "maybe 1 time per week." 4. On 02/23/12 at 8:21 a.m., two ceiling vents in the main dining room were soiled with heavy dust. The vents were located directly over a table utilized by residents for meals and activities. On 02/24/12 the following was observed: 5. At 8:29 a.m., a box fan in room 30 was soiled with heavy dust on the guard and fan blades. The frames of both beds were soiled with heavy dust that rolled up when swiped with the finger. A strong odor of urine and body odor was noted on bed 1. The mattress cover was soiled with food crumbs in the crevices. 6. At 8:33 a.m., in room 24 the frame of one bed and 2 fans were soiled heavy dust. The wallboard just inside the door was marred and split in approximately 6 inch area. 7. At 8:41 a.m. the bed frame in room 65 was soiled with heavy dust. The room was noted ready for resident occupancy.		**to be affected by the same alleged deficient practice and what corrective action will be taken?** · All residents have the potential to be affected, all bed frames were appropriately cleaned on 3/12-3/17/12. An IDT review on 3/9/12 indicated no resident in the facility at this time has the potential to be affected. · Ice Machine vents, Box Fans, Mattress covers and Ceiling vents were cleaned on/by 2/25/12 by housekeeping **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?** · Effective 3/12/12 an updated room cleaning schedule was created to ensure routine cleaning of bed frames and fans, as well as dining room furniture. Housekeeping in-serviced by Environmental Director by 3/19/12 on new schedule and current laundry cleaning schedule which includes all fans in laundry area. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place.**	

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	3.1-19(f)		· Environmental Services Director will do random audit after cleaning is complete to verify compliance. Audits will be conducted weekly for four weeks then monthly for six months to verify adherence to schedule. · Results of audits will be reported to CQI committee.	

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure physician orders to treat a urinary tract infection were followed for 1 of 3 residents reviewed for physician orders in a supplemental sample of 3. (Resident #70) Findings include: The clinical record for Resident #70 was reviewed on 2/23/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, dementia, diabetes type II and urinary tract infection. On 2/22/12 at 11 a.m., the physician ordered Macrobid (to treat a urinary tract infection) 500 mg (milligrams) BID (two times a day) for 7 days. On 2/23/12 at 11:37 a.m., in interview with LPN (Licensed Practical Nurse) #2, he indicated he worked second shift and was unable to get the order for the Macrobid clarified after pharmacy called of the discrepancy in dosage. He passed the concern onto the night shift nurse. He heard the ordered medication had not been started.	F0282	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident # 70's antibiotic was started. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · Licensed Nursing staff will be re-educated by 3/13/12 by the DNS/designee on timely physician notification, and following physician's orders. Post test completed. · All physician orders are reviewed daily by the DNS/designee with follow-up using the CQI minutes tool to ensure physician orders are in place and being followed. · Non-compliance with these practices will result in further education including disciplinary action. · Director of nursing services/designee is responsible to ensure compliance.	03/25/2012

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	Review of the February 2012 Medication Administration Record included, but was not limited to "Macrobid 500 mg po (by mouth) BID x 7 Days" indicated the medication was not given as the initial of the nurse was circled for the 9 p.m. dose on 2/22/12. The explanation given on the reverse side of the Medication Sheet indicated "Macrobid - need clarification order." 3.1-35(g)(2)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** · Licensed Nursing staff will be re-educated 3/13/12 by the DNS/designee on timely physician notification, and following physician's orders. Post test completed. · All physician orders are reviewed daily by the DNS/designee with follow-up using the CQI minutes tool to ensure physician orders are in place and being followed. · Non-compliance with these practices will result in further education including disciplinary action. · Director of nursing services/designee is responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI audit tools for physician notification and change of condition will be utilized weekly x 4 weeks, bi-weekly x 2 months, monthly x 3 months and quarterly thereafter. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for thresholds below 95%.	

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure a resident's pain was being managed for 1 of 2 residents reviewed for pain management in a sample of 15. (Resident #45) Findings include: The clinical record for Resident #45 was reviewed on 2/21/12 at 1 p.m. The resident's diagnoses included, but were not limited to: right above knee amputation and cancer of the bladder. Review of the PRN (as needed) Medication Record for February 2012 indicated the resident was receiving Oxycodone IR (Immediate Release) 5 mg (milligram) tablet. Take 1 tablet by mouth every 4 hours as needed for moderate pain and Oxycodone IR 5 mg, take 2 tablets (10mg) by mouth every 4 hours as needed for severe pain. The original order for Oxycodone IR was ordered on 1/20/12 and signed by the physician. Review of the Dose Usage Record for	F0309	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident # 45 no longer resides at this facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · The licensed nurses will be in serviced by the DNS/designee 3/13/12 on pain management. Post test included. · All residents receiving prn pain medications have been reviewed to ensure that the medication is effective in controlling their pain. · Trends in complaints of pain specific locations have been reviewed to ensure the physician has been contacted for further orders. · The director of nursing services/designee is responsible to ensure compliance	03/25/2012

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	February 2012 indicated the following: Oxycodone IR 5 mg tablets (2) for 10 mg were given 2 to 5 times in a 24 hour period on the following days: February 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19. Review of the Initial Minimum Data Set Assessment dated 1/27/12, indicated a care plan for pain management completed. The care plan completed on 2/15/12 included, but was not limited to: "Problem Start Date 2/15/12 Resident has pain related to: decreased mobility, right above knee amputation, requires assistance to complete ADL's (Activities of Daily Living), bladder cancer, PVD (peripheral vascular disease), sacral wound and midback wound. Approach: start date 2/15/12 Administer meds as ordered, non medication interventions such as rest, quiet, environment, therapies as ordered., Notify MD if pain is unrelieved and /or worsening." On 2/23/12 at 3:40 p.m., in interview with the Corporate RN, she indicated the pain medication was for breakthrough pain. After reviewing the sign out record, she indicated the physician would be called related to the resident was taking the medication on a routine basis. On 2/24/12 at 9 a.m., the Administrator provided a pain assessment dated 2/3/12		**What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:** · The licensed nurses will be in serviced by the DNS/designee 3/13/12 on pain management. Post test included. · All pain medications ordered have been reviewed to ensure that the medication is effective in controlling their pain. · Trends in complaints of pain specific to locations have been reviewed to ensure the physician has been contacted for further orders. · The director of nursing services/designee is responsible to ensure compliance · Non-compliance will result in further education including disciplinary action. · Nurse will document effectiveness of pain medication on the MAR. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** · The CQI audit tool for pain management will be utilized daily x 4 weeks, bi-weekly x 2 months, monthly x 3 months and for 2 quarters thereafter. · Findings from the CQI process and trends will be reviewed monthly and an action plan will be	

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	at 4:22 p.m., which included, but was not limited to: "Yes" was answered to the following: currently on routine pain meds, experiencing pain, "Have you had pain or hurting at any time in the last 5 days?" "Has pain made it hard for you to sleep at night over the past 5 days?" "Have you limited your day-to-day activities because of pain?" "Pain in left leg, right hip and back, severe, almost constantly, throbbing, nothing so far has helped much, chronic since admission." 3.1-37(a)		implemented for threshold below 95%.	

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to ensure treatment for a urinary tract infection was implemented timely for 1 of 2 residents reviewed with a history of urinary tract infection in a supplemental sample of 3. (Resident #70) Findings: The clinical record for Resident #70 was reviewed on 2/23/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, dementia, diabetes type II and urinary tract infection. On 2/21/12, the doctor ordered Macrobid (to treat a urinary tract infection) 500 mg (milligrams) BID (two times a day) for 7 days. Resident Progress Notes included, but were not limited to: 02/20/12 6 p.m. "Resident's family in today to visit with	F0315	**F-315 No Catheter, prevent UTI, Restore bladder** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident # 70's antibiotic was started. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · Licensed Nursing staff will be re-educated 3/13/12 by the DNS/designee on timely physician notification, and following physician's orders. Post test completed. · All physician orders are reviewed daily by the	03/25/2012

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	resident. Family concerned because resident stated her R (right) side was hurting. Nurse checked resident R side and asked resident if it hurt when touched. Resident stated "not that bad but just a little." No bruising noted, no visual injuries, no s&s (symptoms & signs) of injury. Family notified. Family stated that 'resident just hasn't been acting right' and requested a U/A (urinalysis) on resident...." Documentation was lacking of a further assessment of the resident's urinary output, color, odor and pain or burning on urination. "...MD notified, new order for U/A C&S (culture & sensitivity) to be done via straight cath. MD will be in tomorrow to see resident. family notified of new order for U/A...." 02/22/12 6:22 PM "M.D. in to see res, new order for antibiotic received, related to UTI, family and pharmacy notified." 02/23/2012 8:53 AM "Physician to see resident in facility. New clarification order for Macrobid to be changed to 100 mg PO (by mouth) BID. New order for ultrasound of kidneys, ureters for hematuria. family notified." Review of the Urinalysis dated 02/22/2012 at 23:30 (11:30 p.m.)		DNS/designee with follow-up using the daily minutes tool to ensure physician orders are in place and being followed. · Non-compliance with these practices will result in further education including disciplinary action. · Director of nursing services/designee is responsible to ensure compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** · Licensed Nursing staff will be re-educated 3/13/12 by DNS/designee on timely physician notification, and following physician's orders. Post test completed. · All physician orders are reviewed daily by the DNS/designee with follow-up using the daily minutes tool to ensure physician orders are in place and being followed. · Non-compliance with these practices will result in further education including disciplinary action. · Director of nursing services/designee is responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI audit tools for	

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	included, but was not limited to: "Clarity Turbid (cloudy) Abnormal (Normal - clear); Blood 3+ Abnormal (Normal - Negative); Protein 2+ Abnormal (Normal - negative); Nitrite Positive normal negative; Leukocytes, 4+ (Normal - Negative); White Blood Cells > (greater than) 50 (Normal -Negative) a culture would be performed. Review of the February 2012 Medication Administration Record included, but was not limited to "Macrobid 500 mg po (by mouth) BID x 7 Days" indicated the medication was not given as the initial of the nurse was circled for the 9 p.m. dose on 2/22/12. The explanation given on the reverse side of the Medication Sheet indicated "Macrobid - need clarification order." On 2/23/12 at 11:37 a.m.,, in interview with LPN (Licensed Practical Nurse) #2, he indicated he worked second shift and was unable to get the order clarified. He passed the concern onto the next shift nurse. He heard the ordered medication had not been started. On 2/23/12 at 3:40 p.m., in interview with the Corporate Registered Nurse, she indicated pharmacy questioned the dose as there were no 500 mg tablets, only 50 and 100.		physician notification and change of condition will be utilized weekly x 4 weeks, bi-weekly x 2 months, monthly x 3 months and quarterly thereafter. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for thresholds below 95%.	

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	3.1-41(a)(2)			

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	155697	A. BUILDING 00 B. WING	02/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on record review, observation and interview, the facility failed to ensure the proper care was given related to tracheostomy care. This affected 1 of 1 resident reviewed with a tracheostomy in a sample of 15. (Resident #50) Findings included: Review of the clinical record for Resident # 50 on 02/21/2012 at 1:15 p.m., indicated diagnoses including, but not limited to, status post motor vehicle accident, tracheostomy (airway tube), gastrostomy tube (feeding tube), seizures. On 2/22/2012 at 2:00 p.m., during observation of care given to Resident #50, Registered Nurse (RN) # 1 put on gloves and set up for tracheostomy care. RN # 1 removed oxygen and removed old	F0328	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #50 has passed away **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · Licensed Nursing staff will be re-educated 3/13/12 on tracheostomy care by the DNS/designee. Post test included. · Licensed Nurses will be checked off on tracheostomy care on or before 3/25/12 by the Staff Development Coordinator/designee. · Non-compliance with these practices will result in further education including disciplinary action.	03/25/2012

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	dressing from around outer trachea and then removed inner cannula and removed gloves. RN # 1 applied sterile gloves and poured hydrogen peroxide into container and proceeded to wet a cotton applicator with solution and wiped inside trachea. RN # 1 wet a new cotton applicator and wiped around the outside of the outer trachea and on Resident #50's skin and then inside trachea with same cotton applicator. RN # 1 took off sterile gloves and opened normal saline (NS) and put on non-sterile gloves and proceeded with rinsing off the trachea. RN # 1 took a 4x4 pad and wet it with the NS and wiped inside the trachea and then got a new 4x4 pad and wet it with the NS and wiped around outside and on resident's skin. RN # 1 took a pipe cleaner and dried inside the trachea and used new pipe cleaner and wiped around outside and on resident's skin. RN #1 put a new trach collar on and fastened, and then removed gloves and washed hands.		· Director of nursing services/designee is responsible to ensure compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · Licensed Nursing staff will be re-educated on tracheostomy care 3/13/12 by the DNS/designee. Post test included. · Licensed Nursing staff will conduct validation audits for tracheostomy care on or before 3/25/12 by the Staff Development Coordinator/designee. · Licensed Nursing staff will conduct validation audits for hand washing on or before 3/25/12 by the Staff Development Coordinator/designee. · Non-compliance with these practices will result in further education including disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The CQI skills check off for tracheostomy care will be utilized weekly x 4, bi-weekly x 2 months, monthly x 3 and quarterly thereafter. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented	

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	On 2/22/2012 at 5:00 p.m., review of the policy and procedure for "Tracheostomy Care" indicated, but was not limited to; "Skill....wash hands.....dry tracheostomy area thoroughly using a 4x4 gauze sponge..." On 2/22/2012 at 4:00 p.m., in an interview with the Corporate RN # 2, she indicated she would expect that nursing would wash their hands before and after tracheostomy care. On 2/24/2012 at 1:40 p.m., review of the current "HAND WASHING POLICY AND PROCEDURE" provided by Administration indicated, but was not limited to; "A. Purpose 1. To prevent the spread of infectious disease B. Equipment 1. Soap 2. Water 3. Hand towel 4. Alcohol gel D. Procedure ... 3. Decontaminate hands before and after having direct contact with		for thresholds below 95%.	

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	patients..... 4. Decontaminate hands before donning gloves (clean or sterile) *this includes the changing of gloves in the middle of any procedure...." 3.1-47(a)(4)			

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F0356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to ensure the daily nurse staffing data was posted on February 21, 2012. This had the potential to affect all 75 residents residing in the facility and their visitors.	F0356	It is the practice of this provider to ensure that nurse staffing information is posted on a daily basis. **What corrective action(s) will be accomplished for those**	03/25/2012

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	Findings include: On entrance to the facility, on 2/21/12 at 8:40 a.m., the posted Daily Staffing was dated 2/17/12. The form was outside of the Administrative Offices. In interview with the Administrator at this time, he indicated it would be changed. 3.1-13(a)		**residents found to have been affected by the alleged deficient practice?** · Staffing information was posted on 2/21/12. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** · All residents had the potential to be affected. Staffing information was posted on 2/21/12 for all residents and visitors to review. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?** · On 2/21/12 Staffing Coordinator was re-educated by Executive Director on regulation regarding daily positing of staffing and appropriate form to use. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place.** · Executive Director will do random audits weekly for four weeks then monthly for six months to verify compliance. · Audit results will be reported to	

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			CQI monthly.	

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on record review, observation and interview, the facility failed to maintain	F0441	**What corrective action(s) will be accomplished for those**	03/25/2012

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	standards of infection control related to hand washing prior to care given on a gastrostomy tube (feeding tube) and a tracheostomy (airway tube). This affected 1 of 1 resident observed for G-tube and tracheostomy care in a sample of 15. (Resident #50) Findings included: Review of the clinical record for Resident # 50 on 02/21/2012 at 1:15 p.m., indicated diagnoses including, but not limited to, status post motor vehicle accident, tracheostomy (airway tube), gastrostomy tube (feeding tube) and seizures. On 2/22/2012 at 2:00 p.m., observation of care given to Resident #50 was watched. Registered Nurse #1 (RN) entered the room and explained to resident what she was going to do, and she then proceeded with setting up equipment for flushing the gastrostomy tube (G-tube) and checking placement. RN #1 put the tube feedings on hold and filled two Styrofoam cups, each with 120 cc water. RN #1 put gloves on and placed stethoscope on abdomen and checked		**residents found to have been affected by the deficient practice?** · Resident #50 has passed away **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · Licensed Nursing staff will be re-educated on tracheostomy and gastrostomy care by the DNS/designee. Post test included. · Licensed Nursing staff have validation complete on tracheostomy and gastrostomy care on or before 3/25/12 by the Staff Development Coordinator/designee. · Non-compliance with these practices will result in further education including disciplinary action. · Director of nursing services/designee is responsible to ensure compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · Licensed Nursing staff has been re-educated on tracheostomy, gastrostomy care	

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	placement using a 30 cc air bolus. RN # 1 removed the stethoscope and turned feedings back on and then cleaned up G-tube supplies and removed gloves. RN # 1 proceeded to put a new set of gloves on and set up for tracheostomy care. RN # 1 removed oxygen and removed old dressing from around outer trachea and then removed inner cannula and removed gloves. RN # 1 applied sterile gloves and poured hydrogen peroxide into container and proceeded to wet a cotton applicator with solution and wiped inside trachea. RN # 1 wet a new cotton applicator and wiped around the outside of the outer trachea and on Resident #50's skin and then inside trachea with same cotton applicator. RN # 1 took off sterile gloves and opened normal saline (NS) and put on non-sterile gloves and proceeded with rinsing off the trach. RN # 1 took a 4x4 pad and wet it with the NS and wiped inside the trachea and then got a new 4x4 pad and wet it with the NS and wiped around outside and on resident's skin.		and hand washing by the DNS/designee. Post test included. · Licensed Nursing staff will be checked off on tracheostomy and gastrostomy care on or before 3/25/12 by the Staff Development Coordinator/designee. · Non-compliance with these practices will result in further education including disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI skills check off for tracheostomy and gastrostomy care will be utilized weekly x 4, bi-weekly x 2 months, monthly x 3 and quarterly thereafter. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for thresholds below 95%.	

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	RN #1 took a pipe cleaner and dried inside the trachea and used a new pipe cleaner and wiped around outside and on the resident's skin. RN #1 put a new trach collar on and fastened, and then removed gloves and washed hands. On 2/22/2012 at 4:00 p.m., in an interview with the Corporate RN #2, she indicated she would expect that nursing would wash their hands before and after G-tube care and trachea care. On 2/24/2012 at 1:40 p.m., review of the current "HAND WASHING POLICY AND PROCEDURE," provided by Administration, indicated, but was not limited to: "A. Purpose 1. To prevent the spread of infectious disease B. Equipment 1. Soap 2. Water 3. Hand towel 4. Alcohol gel D. Procedure ..... 3. Decontaminate hands before and after having direct contact with			

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	patients..... 4. Decontaminate hands before donning gloves (clean or sterile) *this includes the changing of gloves in the middle of any procedure....." On 2/24/2012 at 2:40 p.m., review of RN #1's General Orientation Acknowledgement Form dated 8/5/2011, indicated, but was not limited to: "Handwashing, Masking, Gloving, Gowning Techniques...Universal Precautions...Infection Control Procedures...." These were signed off as being completed. 3.1-18(j) 3.1-18(l)			

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F0456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on record review, interview and observation, the facility failed to ensure the Hoyer and Stand Up lift batteries were charged according to manufacturer's instructions, for 3 of 4 Hoyer lifts observed. This deficient practice had the potential to affect 15 residents who utilize the Hoyer/Stand Up lifts. Findings include: On 02/20/12 during the confidential group interview two of 13 residents (#100 and #101) indicated that the Hoyer and Stand Up lifts did not always function as the batteries were low. On 02/23/12 at 8:22 a.m., two Hoyer and two Stand Up Lifts were observed stored in a shower room. One had a sign indicating it was out of order. The battery on both Stand Up Lifts failed to operate the equipment when the controls were pushed by LPN #1 (Licensed Practical Nurse). LPN #1 obtained a battery from the charging station and placed it in the lift. The battery lacked enough charge to	F0456	**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** · The hoyer lift and stand-up lift batteries are charged per manufacturer's instructions. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** · Residents transferred with a hoyer or stand-up lift have the potential to be affected by the alleged deficient practice. · Nursing staff have been in-serviced on charg · ing the hoyer/stand-up lift batteries by the DNS/designee on 2/24/12. Post test included. · Extra batteries and chargers have been ordered to ensure availability of fully charged batteries for use. · A log sheet has been initiated so as when a battery is placed on a charger it is charged for at least 6 hours per the manufacturer's instructions. · The c.n.a. will charge the hoyer batteries at all times and the	03/25/2012

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	operate the lift. When asked at this time what system was in place to ensure the batteries were charged, LPN #1 indicated the Certified Nursing Assistants would place the battery on the charger for recharging. No system was in place to ensure the batteries were left in the charger until fully charged. The Maintenance Director provided the manufacturer's instructions for the lifts on 02/23/12 at 10:40 a.m. Upon review at this time, the instructions indicated the batteries needed to be charged for 4 to 6 hours. At this time, the Maintenance Director indicated he was ordering extra batteries today. 3.1-19(bb)		maintenance department will check the batteries to ensure they are charged and properly functioning each morning. · Non-compliance with these practices will result in further education including disciplinary action. · DNS/designee to monitor for compliance. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?** · Nursing staff have been in-serviced on charging the hoyer/stand-up lift batteries by the DNS/designee on (date). Post test included. · Extra batteries and chargers have been purchased to ensure availability of fully charged batteries for use. · A log sheet has been initiated so as when a battery is placed on a charger it is charged for at least 6 hours per the manufacturer's instructions. · The c.n.a. will charge the hoyer batteries at all times and the maintenance department will do random weekly checks to ensure are charged and properly functioning. · Non-compliance with these practices will result in further education including disciplinary action.	

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			· DNS/designee to monitor for compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The maintenance supervisor/designee will utilize the hoyer lift battery tool to ensure batteries are charged daily x 4 weeks, bi-weekly x 3 months and quarterly x 3 thereafter. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for thresholds below 95%.	